PRINTED: 09/29/2023
FORM APPROVED

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0225	A. BUILDING: _____ B. WING _____	08/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ASSISTED LIVING	1302 SOUTH MAIN STREET CLARION, IA 50525

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 22 Number of tenants with cognitive impairment: 1 Total census: 23 The following regulatory insufficiency was cited during the recertification visit conducted to determine compliance with certification for an Assisted Living Program.	A 000		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to update service plans as needs changed for 1 of 4 tenants reviewed (Tenant #1). Findings include: On 8/28/23 review of Tenant #1's record revealed on 8/30/22 Tenant #1 was diagnosed with cellulitis of the lower extremity. He had an open	A 350	1.) Service plan updated on resident #1. RN will identify and verify all service plans are updated when changes occur or at least annually. 2.) RN's will be reeducated on regulatory requirements of service plans. 3.) Administrator or Designee will monitor charts for compliance every 90 days. 4.) Plan of correction will be completed by 10/27/2023. Ryan Locke - adm. 10/3/2023	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

PRINTED: 09/29/2023
FORM APPROVED

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0225	A. BUILDING: _____ B. WING _____	08/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ASSISTED LIVING	1302 SOUTH MAIN STREET CLARION, IA 50525

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 350	Continued From page 1 wound at the time. On 10/13/22 his wounds to the lower extremity were noted as healed. Further review revealed on 8/10/23 Tenant #1 had seen his doctor for a wound on his left leg. Tenant #1 requested this appointment due to having a history of cellulitis. The doctor ordered Keflex four times a day for seven days. His leg was to be elevated and dressing changes daily. A wound nurse was to evaluate the area. Review of Tenant #1's service plan dated 7/17/23 revealed the plan was not updated to add the treatments as ordered by the tenant's doctor concerning his leg wound/cellulitis. On 8/28/23 at 5:00 p.m. the Registered Nurse and the Administrator A confirmed this finding	A 350		

ok